MARKET CONDUCT EXAMINATION

OF

PROVIDENT LIFE & ACCIDENT INSURANCE COMPANY

AT

CHATTANOOGA, TENNESSEE

AS OF

SEPTEMBER 1, 1997

December 5, 2000

The Honorable Deborah Senn
Washington Insurance Commissioner
Insurance Building
PO Box 40255
Olympia, Washington 98504-0255

Dear Commissioner Senn:

Pursuant to your instructions and in compliance with the statutory requirements of RCW 48.44.020, an examination has been conducted to review the corporate affairs and market conduct activities of:

Provident Life & Accident Insurance Company
One Fountain Square
Chattanooga, Tennessee 37402

Scope of Examination

The market conduct examination of Provident Life and Accident Insurance Company, henceforth referred to as the "Company" or, "Provident" was conducted in accordance with policies and procedures established by the Office of the Insurance Commissioner and the National Association of Insurance Commissioners. The examination covered January 1, 1995 through September 1, 1997.

TABLE OF CONTENTS

EXAMINATION REPORT CERTIFICATION

This examination was conducted in accordance with the Office of the Insurance Commissioner and National Association of Insurance Commissioners market conduct examination procedures. This examination was performed by Leslie Krier and George Lazur, who participated in the preparation of this report.

I certify that the foregoing is the report of the examination, that I have reviewed this report in conjunction with pertinent examination work papers, that this report meets the provisions for such reports prescribed by the Office of the Insurance Commissioner, and that this report is true and correct to the best of my knowledge and belief.

Leslie A. Krier, AIE, FLMI
Chief Market Conduct Examiner
Office of the Insurance Commissioner
State of Washington

FOREWORD

Throughout the report, where cited, RCW refers to the Revised Code of Washington, and WAC refers to Washington Administrative Code.

SCOPE

Time Frame

The examination covered the target company operations from the period January 1, 1995 through September 1, 1997.

Matters Examined

The focus of the examination was the individual and group long term disability business that encompassed the following areas of operations:

- Individual and group long term disability claims
- Individual and group long term disability complaints
- Individual and group disability policy forms.

HISTORY OF THE COMPANY
TERRITORY OF OPERATION

Provident Life and Accident Insurance Company was originally incorporated in Tennessee in 1887. In 1910 it was reincorporated as a stock company, Provident Life and Accident Insurance Company of Chattanooga, Tennessee. The Company was admitted to the State of Washington on June 8, 1926. In 1935, it adopted its current name of Provident Life and Accident Insurance Company.

Life insurance members of the Provident Life & Accident Group are The Paul Revere Life Insurance Company; The Paul Revere Protective Life Insurance Company; The Paul Revere Variable Annuity Insurance Company; Provident Life and Accident Insurance Company; Provident Life and Casualty Insurance Company and Provident National Assurance Company.

Subsequent Event: On June 30, 1999, Provident Life and Accident Insurance Company and UNUM Insurance Company merged into UNUMProvident Corporation.

The Company is licensed in all states except New York, the District of Columbia, Puerto Rico and all Canadian provinces and territories.

The Company Directors are:

James Harold Chandler
Elaine Debra Rosen
Burton E. Sorensen
James Leaner Moody, Jr.
Floyd Dean Copeland
Thomas R. Watjen

COMPLAINT REVIEW

COMPLAINT HANDLING PROCEDURES

During the exam period, the Company had a five-page section on Complaint Handling and Tracking in their Market Conduct Compliance Manual. The Consumer Relations Administrator in the Law Department maintained complete files on all complaints received from state insurance departments, consumers, producers, shareholders or any other source. The complaint was reviewed and sent to the appropriate company department to address the problem. The Consumer Relations Administrator was responsible for keeping a copy of the complaint file including all correspondence and investigation paperwork. If a complete response to the complainant was not possible within the stated time limit, the department handling the complaint was instructed to send an interim response to the appropriate state insurance

department or complainant.

Of the 13 complaints reviewed, the Company took longer than 15 working days to substantively respond to the OIC about the complaint in four (4) instances. (See Appendix 1.)

Standard #1 The Company must respond to inquiries from the Office of the Insurance Commissioner within 15 business days of receipt of the inquiry. WAC 284-30-650 (See Appendix 1)

Total Number of Complaints	33
Complaints Reviewed:	13
# Violations:	4
Percentage with Violations:	31% (outside 5% tolerance limit)

Result: The Company did not meet this standard.

Subsequent Event: After the merger of UNUM and Provident on June 30, 1999 a new Consumer Complaint Policy and Procedures manual was developed. This includes weekly reporting requirements as well as periodic reports to management to ensure the prompt handling of all complaints.

OIC COMPLAINT REVIEW

There were 33 OIC complaints during the examination period. Thirteen (13) were randomly selected for review as part of the examination process. Five (5) complaints concerned post claim underwriting, four (4) concerned delay in payment and four (4) concerned contract provision enforcement.

Of the five (5) complaints involving post claim underwriting, we reviewed the underwriting and claim files on each.

- In one case, the company rescinded the Business Overhead Expense policy because the post claim investigation revealed that the insured had not accurately stated his income on the application. There is no evidence that this information was corroborated during the underwriting process, even though the Company's published underwriting requirements state that verification of income is required.
- In two cases, the Company tried to deny claims because they had not underwritten reinstatement applications. There is no evidence in the files that the information contained in the reinstatement applications was questioned by the underwriting department during the reinstatement process.
- Four (4) of the five (5) claims in this category were paid after OIC intervention.

UNDERWRITING DOCUMENTS REVIEW

The Company provided us with nine (9) underwriting guides and documents. We reviewed these to determine if there were reasonable and consistent underwriting guidelines for the disability policies.

Seven (7) of these documents were intended to be used by agents. There were four (4) underwriting guides updated with new product information, two (2) product binders and a guide for ordering attending physician statements.

There were two items used by Home Office underwriting staff, an underwriting manual and the underwriting notebooks.

The underwriting guides and documents state very clearly the medical and financial documentation needed to process new applications for coverage. As noted in the claims section, there were situations where the underwriters did not require the stated documentation be sent to approve the applications. See the Post Claim Underwriting section of this report.

CLAIMS DEPARTMENT REVIEW

The Company provided us with claims training materials, information on the structure of the claims department, information on claims handling procedures and a list of Washington claims for the examination period.

CLAIMS TRAINING DOCUMENTS

The Company advised that they did not have a formal training program for claims staff. They had a six-week course that was required for all new claims personnel. This session was different for each new group of processors. The Company did not have a formal procedures manual during the examination period. In a discussion with the Company, the examiners asked specifically if the Company had a claims manual. The Company's response was that they did not have a claims manual. They teach the claims representatives their philosophy and procedures in a training class when they are first hired. The Company felt that a manual was too restrictive, and that their philosophy was to handle each claim individually.

The Company philosophy contains four (4) statements. Those are:

- Thorough, fair, objective evaluation

- Pay claims promptly, with high level of service
- Assist claimant's return to work
- Defend against illegitimate claims

After many discussions, the Company provided the examiners with a collection of documents (1,517 pages) which included training material from new claim staff training sessions. The training material included the following:

- proposals for establishment of training and quality audit programs in 1994 and 1995
- a 6 volume training manual for a 12 week training course.

Subsequent Event: In conjunction with the merger of UNUM and Provident, a claims manual was created. The manual was delivered to the Maine Insurance Department in December 1999 as a requirement for the merger. Currently, the Company keeps the manual on their intranet, and it is updated on a regular basis.

Training & Quality Audit Program Proposal

Among the claims training materials, the first item was an undated memo. It discussed the need for Aa very organized approach to orientation and a very structured, condensed training program.≅ We did not find evidence that this program had been instituted at the Company. This material also describes the organization of the the Training Q/A Unit, which was responsible for training new and experienced staff as well as performing ongoing quality audits. In the material provided to examiners was a list showing the "Overall Responsibilities of Training Function". Listed functions included: ACoordinate the execution of formalized training program≅ and AMaintain Claims Manual and produce updates as necessary.≅ After reading this memo, the examiner again asked for a copy of the formalized training plan and the Claims Manual. The Company maintained that no such documents were available.

Subsequent Event: The Company set up a Training Program that was phased in from 1995 to 1998. The Training Department was fully operational by the end of 1998.

Training Manual

The material presented to the examiners as the materials associated with one of the training sessions was well organized and appeared to cover a wide range of claim processing procedures. There were six (6) volumes of material. However, the Company stressed that this was not a set program, but changed each time a new class was scheduled, depending on the people chosen as trainers.

The Company stated that a Training and Quality Assurance program had been established. The program called for broad-based training to take place every other month for experienced claim personnel, with quality assurance reviews of each claims representative done twice each year. In addition, each unit was to conduct specialized training in its field, such as mental health issues or cardiac issues. At the time of the exam, we were informed that only the semi annual quality assurance reviews of claims representatives were being done. The remainder of the proposed Training and Quality Assurance program had not been implemented.

CLAIMS DEPARTMENT ORGANIZATION

The Company handles claims in four locations: the Chattanooga, TN Home Office; Worcester, MA (formerly Paul Revere=s Home Office); Springfield, MA (TPA for Equitable); and Burlington, Ontario for Canadian claims. There are approximately 750 people in the disability claims departments. These include: Office Claims Representatives, Field Claims Representatives, Rehabilitation Specialists, Disability Case Managers (who are Nurses), Physicians, Claims Consultants (experienced claims specialists) and Unit Claims Managers. There are also 1,000 nurses at 120 locations of GENEX, a subsidiary that handles case management and vocational rehabilitation referrals.

CLAIMS HANDLING PROCEDURES

At the time of the examination, the Company was in the process of integrating disability claims for all types of policies. They were previously handled in different units for individual, group, or associations, even if the claimant had multiple policies for one claim incident. Under the new system, all claims for the same incident were handled in the same area.

Claims were received in the Intake Unit at the rate of about 1,500 every month. The Intake unit sorted the claims according to the type of claim. They were then sent to the appropriate unit for processing. The claim was reviewed by the Unit Claim Consultant, then assigned to a claims representative with specific skills and experience for that type of disability. Most new claims were reported by phone. A letter was sent to the claimant on the same day with the necessary claim forms and instructions on how to complete the forms. Claims fall into one of three stages:

Stage I: Pay and Close: these claims go to a general claims unit for simple injuries or illnesses with short durations.

Stage II: GENEX: these claims go to a general claims unit for short term Return to Work (RTW) claims without intervention using duration guidelines, and short term RTW claims with intervention using a medical management plan.

Stage III: Existing Disability Income Process, for complicated injuries or illnesses with long term durations using impairment-based claims management: these go through a multi-step process:

- X Assignment to specialized claim units: Orthopedic, Psychiatric, Cardiac, or General Medical.
- X Automated Triage: three-point contact with the claimant, attending physician and employer.
- X Establishment of a medical management pathway to facilitate the claimant's return to work.
- X Validation Activities: claimant interviews, physician interviews, employer interviews, medical records review, medical referrals and disability case management reviews.
- X Return to Work Activities: rehabilitation referrals, GENEX referrals, independent medical examinations (I.M.E.s), 'Field Referrals' and 'Round Table Reviews.'
- X Ongoing Claim Management: continued reviews and referrals to bring the claim to a resolution. The majority of resolutions involve a return to work at the same job. Other types of resolutions are vocational rehabilitation, expiration of the benefit period, death of the claimant and unjustified claims.

A Claims Representative may not take adverse action on a claim alone. It must be referred to a Claims Consultant for review.

CLAIM FILE REVIEW

The Company provided a list of 656 claims. This list was to include all open and closed claims for Washington residents during the examination period. The examiners randomly selected 100 claims from the first listing for review. Upon review of the 100 sample claim files, it was discovered that the list contained claims for residents of other states, and claims of other insurers, from their third party administration business. The Company re-ran the claim listing using the correct criteria. There were 595 claims on the new listing.

A new sample was not selected after the discrepancy was discovered. Of the 100 selected claim files, 12 did not involve Washington residents. Four (4) were third party administration claim files. The net sample size after deducting these 16 claims was 84.

Final actions on the sample claims were:

X	Open with payments still being made for disability:	9
X	Open with no payments made to date:	2

X	Closed with payment:	41
X	Closed without payment – no forms filed:	15
X	Denied as non-compensable:	12
X	Policies rescinded	5

During the claim review, the examiners found nine (9) of the 84 claims contained information indicating that, as part of the claim adjudication process, the Company was verifying the application information. In these nine (9) cases, the claim processor came to the conclusion that the applicant had misrepresented pertinent information on the application. As a result of these investigations, five (5) policies were rescinded, one (1) claim was denied and three (3) claims were paid and the policies left in force.

The Company rescinded the policies based on their interpretation of the Time Limit on Certain Defenses. This policy provision states:

"1. After two years from the Effective Date of this policy, no misstatements, except fraudulent misstatements, made by you in the application for this policy will be used to void the policy or to deny a claim for loss incurred or disability that starts after the end of such two year period.

"2. No claim for loss incurred or disability that starts after two years from the Effective Date of this policy will be reduced or denied on the grounds that a sickness or physical condition not excluded by name or specific description had existed before the Effective Date of this policy."

The examiners reviewed the claim file and the underwriting/application file for each of the nine (9) claims in question. Of these nine (9) claims, four (4) were claims for business overhead expense policies. In three (3) of these, the policies were rescinded because the Company felt that the insured had fraudulently misrepresented their income on the application. The policies were rescinded under the Time Limit on Certain Defenses section of the policy. In reviewing the application files there was no indication or documentation that the figures presented on the applications were ever verified by the underwriter.

Another breakdown of these nine (9) claims shows that five (5) were on policies that had been in force less than two (2) years. The other four (4) had been in force longer than two (2) years. This is significant because after two (2) years the policy states that there must be fraudulent misrepresentation at the time of application in order for the Company to deny the claim and rescind the policy. It was the Company's decision that there was misrepresentation in the form of omitted or incorrect information given with the application. It did not appear that the Company had verified the application information during underwriting.

When asked about this, the Company stated that the underwriters followed the guidelines in effect at the time the application was processed. The examiners found that this did not always occur. For example, when the underwriting files were reviewed for the policies in question, there was no evidence that an IRS form W-2 had been submitted and verified on all applicants even though the underwriting guidelines furnished to the examiners show that this is a required form.

The five (5) that had been in force less than two (2) years were rescinded based on the post-claim investigation. Two (2) of these were rescinded for omitted medical information on the application. In reviewing the underwriting files and applications, the examiners agree with the Company's position that the medical information on these two (2) was omitted. The other three (3) policies were rescinded because the financial data submitted at claim did not match the data supplied on the application. In reviewing the underwriting files and applications on these policies, it appears that the Company either failed to get the financial data at application or did not verify the information on the application. However, the Company stated to the examiners that they felt that the guidelines in place at the time the applications were underwritten were followed and that the Company acted in accordance with their guidelines.

Of the claims where the policy had been in force longer than two (2) years, three (3) were paid and one (1) was denied as the disability did not exceed the elimination period. There is evidence in the claim file that if the elimination period had been met, the Company felt that omitted medical information on the application would have been cause for "fraudulent misrepresentation" and the policy would have been rescinded. In all cases, the claim investigation period was significantly protracted.

Claim Standards

We reviewed the 84 claims files to determine compliance with Washington Administrative Code and the Revised Code of Washington. The following is a summary of our findings.

Standard #2: Upon notification of a claim, acknowledge receipt of the claim to the claimant within ten working days. WAC 284-30-360 (1) and (4)

The Company sends a letter of acknowledgment with claims forms within ten working days of notice from the claimant.

Total Claim Population	595
# Claims Reviewed	84
# Violations	0
Percentage with Violations	0 % (within tolerance of 5%)

Result: The Company met this standard.

Standard #3: Investigation of a claim shall be completed within 30 days after notification of a claim unless the investigation cannot be reasonably completed within this time frame. WAC 284-30-370 (See Appendix 2)

In many cases the Company did not receive requested information from claimants (such as claim forms and proofs of loss), employers (job descriptions and income information) and doctors (attending physicians statements) within the 30 day time limit. The Company does not have control over receiving information from outside sources, but they do consistently follow up on outstanding requests. The violations noted in this section are only those situations where the claim file appeared to contain all documents necessary to make a determination, but the determination was not made within the stipulated time frame.

Total Claim Population	595
# Claims Reviewed	84
# Violations	4
Percentage with Violations	4.76% (within 5% tolerance level)

Result: The Company met this standard.

Standard #4: Acceptance or denial of a claim must be made within 15 working days after receipt of completed proofs of loss. WAC 284-30-380 (1) (Appendix 3)

In reviewing claims for this standard, completed proof of loss is defined as receipt of all material requested as part of the adjudication process, such as attending physicians statements, financial statements, independent medical examinations, etc.

Total Claim Population	595
# Claims Reviewed	84
# Violations	4
Percentage with Violations	4.76% (within 5% tolerance level)

Result: The Company met this standard.

Standard #5: Denial of a claim on the basis of a specific policy provision, condition or exclusion must be given to the claimant in writing and the file must contain a copy of the denial notification. Denials for any other reason must be noted in the file. WAC 284-30-

380 (1) and (2), WAC 284-30-330 (13)

Of the 84 files reviewed, 31 were denied benefits. There were written denial letters in all the files.

Total Claim Population	595
# Claims Reviewed	31
# Violations	0
Percentage with Violations	0 % (within the 5% tolerance level)

Result: The Company met this standard.

Standard #6: When a claim determination cannot be made within 15 working days of receipt of completed proofs of loss, notification must be given to the claimant within the 15 day time limit, and each 30 days thereafter. Notification must contain the reason for the delay in the investigation. WAC 284-30-380 (3)

Total Claim Population	595
# Claims Reviewed	84
# Violations	0
Percentage with Violations	0 % (within the 5% tolerance limit)

Result: The Company met this standard.

Standard # 7: Claim files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and dates of such events can be reconstructed. WAC 284-30-340 (Appendix 4)

Of the 84 claims reviewed there was poor file documentation in 5 files. One claim had no indication it had been paid but appeared on the Company payment records as paid. One claim file was missing documentation but contained information from a second claim file. The other two claims were poorly organized and not complete, with one containing five items with no date stamp.

Total Claim Population	595
# Claims Reviewed	84
Violations	5
Percentage with Violations	5.95% (outside 5% tolerance limit)

Result: The Company did not meet this standard.

Standard #8: If claim payments are made without a final determination on the claim, the company must advise the claimant of possible reimbursement in writing. WAC 284-30-350 (7) (Appendix 5)

There were 9 claims in the sample that involved a Reservation of Rights situation in which the Company made payments prior to a final determination. Four (4) of these did not include a copy of a letter to the claimant explaining the Reservation of Rights and the possible need for reimbursement of claim dollars paid if the final determination was denial.

Total Claim Population	595
# Claims Reviewed	9
# Violations	4
Percentage with Violations	44.44% (Outside 5% tolerance limit)

Result: The Company did not meet this standard.

Standard #9: An investigation or payment of claim may not be delayed by requiring a claimant or physician to submit preliminary claim forms and subsequently requiring additional submissions of substantially the same information. WAC 284-30-330(11) (Appendix 6)

Of the claims reviewed, four (4) contained requests for duplicate information. In one (1) claim file, an Attending Physician Statement (APS) was ordered even though the same APS was already in the file. One (1) claim had two (2) APS's ordered from the same physician for the same period of time.

Total Claim Population	595
# Claims Reviewed	84
# Violations	4
Percentage with Violations	4.71 % (within 5% tolerance level)

Result: The Company met this standard.

Standard # 10: Adopt and implement reasonable standards for the prompt investigation of claims. WAC 284-30-330(3)

The Company did not have written standards for claims adjudication. We also asked to review a claims procedure manual, but the Company maintained that they had no claims manual. Their justification for this was that they felt that every claim was handled individually, therefore no

written standards or procedures were necessary.

Result: The Company did not meet this standard.

Standard #11: Reasonable standards have been adopted to ensure prompt payment of claims once the obligation to pay has been established. WAC 284-30-330(16)

The Company does not have written procedures or standards for claim processing.

Result: The Company failed to meet this standard.

Subsequent Event: In conjunction with the merger of UNUM and Provident, a claims manual was created. The manual was delivered to the Maine Insurance Department in December 1999 as a requirement for the merger. Currently, the Company keeps the manual on their intranet, and it is updated on a regular basis. They also developed the Customer Services Guidelines manual that sets standards for the claims handling process.

POLICY FORM REVIEW

The Company provided 21 disability policy forms for review. They provided both a specimen contract and a copy of their filing with the Office of the Insurance Commissioner. In addition to verifying that the policy forms were filed and approved, we also checked the policies for certain provisions: preexisting conditions, definition of total/partial disability, definition of sickness, Incontestability/Time Limit on Certain Defenses.

We found that all the policies had been approved by the OIC and that they contained the correct language as required by RCW 48.20 and WAC 284-50.

Standard #12: The Company must file all forms for approval by the OIC before they are issued, delivered or used. RCW 48.18.100 (1)

# Policy Forms Reviewed	21
# Violations	0
Percentage with Violations	0% (Within 0% tolerance limit)

Result: The Company met this standard.

Standard #13: The policy language must be at least as specific as the language stated in WAC 284-50-315(6) concerning preexisting condition limits.

# Policy Forms Reviewed	21	
# Violations	0	
Percentage with Violations	0%	(Within 0% tolerance limit)

Results: The Company met this standard.

Standard #14: The policy language must be at least as specific as the language stated in RCW 48.20.052 concerning Time Limit on Certain Defenses/Incontestability provisions.

# Policy Forms Reviewed	21	
# Violations	0	
Percentage with Violations	0.00%	(0% tolerance limit)

Results: The Company met this standard.

Instructions

1. The Company must respond to inquiries from the Office of the Insurance Commissioner within 15 working days of receipt of the inquiry as required in WAC 284-30-650. The Company is instructed to answer any future inquiries in a timely manner as required. (Page 7, Standard #1, Appendix 1)

2. WAC 284-30-340 states that all pertinent claim documents must be kept in the claim file so that the claim may be reconstructed from the documents on file. The Company is instructed to comply with this regulation and ensure that file documentation is complete. (Page 15, Standard #7, Appendix 4)

3. If claim payments are made without a final determination on the claim, the company must advise the claimant of possible reimbursement in writing, per WAC 284-30-350(7). The Company is instructed to send notification letters for all Reservation of Rights claims. (Page16, Standard #8, Appendix 5)

4. The Company is required to adopt and implement reasonable standards for the prompt investigation of claims under WAC 284-30-330(3). The Company is instructed to adopt written claims handling procedures and standards to comply with this requirement. (Standard #10, Page 17)

5. Reasonable standards must be adopted to ensure prompt payment of claims once the obligation to pay has been established as required by WAC 284-30-330(16). The Company is instructed to adopt written claims handling procedures to ensure prompt payment of all claims. (Standard #11, Page 17)

Recommendations

1. The Company must accept or deny a claim within 15 working days after receipt of completed proofs of loss, per WAC 284-30-380(1). The Company is instructed to meet this time requirement for all future claims. (Page 11, Standard #3, Appendix 2)

APPENDIX 1

Standard #1

Complaints with Response Time Greater Than 15 Working Days

Policy Number	Response Time
2099680	58 Days
4080802	37 Days
9610094	28 Days
4032216	30 Days

APPENDIX 2

Standard #3

Claim Investigation Not Complete Within 30 Days

Index Number	Claim Number
36	883817
42	870805
45	887351
90	882985

APPENDIX 3

Standard #4

Accept or Deny Claim Within 15 Day of Complete Proof of Loss Receipt

Item Number	Claim Number
30	870115
36	883817
42	870805
53	866057
83	886785
86	869553
87	869554

APPENDIX 4

Standard #7

All Pertinent Claim Documents Must Be in File

Item Number	Claim Number
14	883027
38	875579
40	883631
49	894888
50	897423

APPENDIX 5

STANDARD #8

Claims Without Reservation of Rights Letters

Item Number	Claim Number
14	883027
28	869019
49	894888
50	897423

APPENDIX 6

STANDARD #9

Duplicate Requests for Information

Item Number	Claim Number
35	886826
38	875579
86	869553
87	869554